What is Recovery?

Clarifying a Concept without a Consensus

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February 22, 2013
Like every parent of a loved one with a psychiatric disability, I scramble for answers to innumerable questions. A family navigating the maelstrom of mental illness craves simplicity, certainty, and above all clarity. Must these be so hard to find? When hearing about the possible genetic origins of schizophrenia, family members can indulge the academic complexity of diagrams that look like circuit boards. But when it comes to the concept of recovery, the ideal around which the whole mental health system is now revolving, shouldn’t there be a pole-star consensus to guide us?

What is recovery? This is the $64,000 question. How can it be measured? Given that the U.S. spends 5.6% of its GDP on mental health (Kliff, 2012), this could be a $312 billion question. But before we answer, let us first take our bearings. We might first ask in what context are we discussing recovery? Recovery of what, for instance? Function? Identity? Dignity? Or recovery from what? A thought disorder? A mood disorder? A substance abuse, developmental, or co-occurring disorder? Or recovery to what? A totally premorbid state, a partial state, or a completely changed state? Or recovery by what? A psychopharmacological or psychosocial approach? Or even recovery for whom? Self? Other? Society? The question has many facets. The challenge of answering is complex indeed.

Many definitions, no consensus

Recovery does not lack for differing definitions. Recovery can be “a deeply personal process of (re)gaining physical, spiritual, mental, and emotional balance when one encounters illness, crisis, or trauma” (Swarbrick, 2006). Recovery can be something that individuals
experience, services promote, and systems facilitate (Jacobson & Greenley, 2001). Recovery can be “the presence of ongoing management of the illness” (Andresen, Oades, & Caputi, 2003). Recovery could be “a state in which patients have experienced improvement in core signs and symptoms to the extent that any remaining symptoms are of such low intensity that they no longer interfere significantly with behavior and are below the threshold typically utilized in justifying an initial diagnosis of schizophrenia” (Andreasen et al., 2005).

What does the government say? The President’s New Commission thought that recovery “is a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment” (New Freedom Commission on Mental Health, 2003). SAMHSA’s National Consensus Statement declares that recovery “is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (Substance Abuse and Mental Health Services Administration, 2003).

This variability of definitions presents a problem for researchers, which partly explains the apparently lack of definitional consensus. Most recovery definitions are too vague or too inclusive: recovery can be anything anyone wants it to be. Certainly this generous idea accords with currently prevailing sector principles, especially of individualism, self-direction, and non-linearity (Substance Abuse and Mental Health Services Administration, 2003). But such imprecise, unrestricted descriptions impede empirical research by eliminating variability in sampling, thus precluding the predictability of recovery. If all are in recovery, none can be not in recovery. Thus, the researcher cannot conduct his research, since without sample variety the null hypothesis that he must disprove cannot be formed (Roe, Rudnick, & Gill, 2007).
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A Framework with Two Dyads

To contain the complexity, it may be helpful to consider recovery as framed by two dyads. The first dyad is between the two agents of recovery, provider and consumer. Providers, specifically medically trained, conceive recovery in terms of their science. Recovery generally implies a cure or an absence of disease (Bellack, 2006), although this classical concept fails to account for disease persistence even with symptom remission, or for an illness producing significant post-morbid change but still a substantial return to function, or to provide a specific basis for empirical study.

There have been significant efforts to develop operational definitions of recovery that can be empirically evaluated. This scientific approach gives rise to the idea that recovery is an outcome, like an achievement, a return to at least semblance of pre-morbidity measured at a specific time. The Remission in Schizophrenia Working Group’s efforts to define remission in schizophrenia is a good example of such effort (Andreasen et al., 2005).

In contrast, consumers define recovery in social, political, and even spiritual terms. Recovery is more than outcomes. It is an evolution of consciousness, a model of care, a process (Spaniol, Wewiorski, Gagne, & Anthony, 2002). Emerging from the civil rights movement and now adopted as an ideal for the Nation’s mental health system, this conceptualization heralds a more collaborative partnership between provider and consumer. At the same time, although anecdotal evidence abounds about the success of recovery as a process, the consumer-oriented recovery definition has been seen to be difficult to test empirically. Many seem to believe that the subjective dimensions of consumer-oriented recovery are not yet sufficiently measurable.

The second dyad is between two aspects of recovery, internal conditions and external conditions (Jacobson & Greenley, 2001). Internal conditions relate to a recovering individual’s
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attitudes, experiences, and personal change. External conditions describe circumstances, events, conditions, and practices which impact or influence the individual in recovery. Key elements of internal conditions have been described by consumers in terms such as “hope, healing, empowerment, and connection” (Jacobson & Greenley, 2001), and “hope”, “self-identify”, “meaning in life”, and “responsibility” (Andresen et al., 2003). External conditions include the political environment (specifically as they relate to civil and human rights), a positive culture of healing, and the availability and quality of recovery-oriented services (Jacobson & Greenley, 2001).

Measurable?

Recovery can be measured, though perhaps not easily. At the scientific end of our first dyad (provider—consumer), many have already proposed operationalized criteria (Bellack, 2006). For example, criteria included in the Brief Psychiatric Rating Score and other measures (Nasrallah, Targum, Tandon, McCombs, & Ross, 2005; Overall & Gorham, 1962) enable researchers to substantiate recovery in terms of outcomes, thus abiding by scientific requirements. At the consumer-oriented end, Noordsy et al. (2002) propose an operational definition with three components that reflect the internal component of our second dyad, e.g., “hope”, “taking personal responsibility”, and “getting on with life”. To these descriptions Noordsy says that several assessment tools can be applied. Others echo this with further descriptions of recovery phases (Andresen et al., 2003; Spaniol et al., 2002). Andresen at al. (2003) also have confirmed the validity of recovery as a measurable outcome.

What next?

Recovery is both an outcome and a process. It can be conceptually framed by a context’s provider-consumer dyad and an individual’s internal-external dyad. It can consist of both a
psychopharmacological component and psychosocial component. It can be studied quantitatively and qualitatively. Its components (e.g., clinical outcomes of interest to providers, internal conditions of individual consumers) have already been measured with a variety of accepted tools. The construct validity of recovery measurement has been established.

Recovery is becoming so important and so accepted that experts are currently exhorting that “it is now realistic to set as a goal for professionals and consumers the feasibility of recovery from schizophrenia for half or more of individuals with the first episode of schizophrenia” (Liberman & Kopelowicz, 2002). Although still not (and maybe never) 100%, this pronouncement is better news to families. For a concept without a consensus, it is quite an advance from the Krappelinian prognostications fashionable not even a century ago, that schizophrenia was an inexorable lifelong slide to pathetically hopeless disability. Yet today there remains too much confusion about what recovery is and about the evidence of what it successfully does.

The parameters of recovery science need more clarity. We need our pole star. Providers and consumers should integrate each other’s thinking and perceptions. Researchers should do more long-term research to confirm the effectiveness of consumer-oriented recovery processes (which are the essence of psychiatric rehabilitation). Funders should extend their funding beyond merely short-term clinical trials of provider-oriented psychopharmacology. Perhaps the governance provisions of the Affordable Care Act can provide national authority that can carefully and collaboratively consider, and then finally create, sufficient consensus standards that will better steer the science of recovery, both as outcome and process.
References


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